

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

TN No. 97-16

Effective 10/1/97

Supersedes

TN No. NEW

Approval Date FEB 17 1998

**FLORIDA TITLE XIX INPATIENT HOSPITAL
REIMBURSEMENT PLAN
VERSION XVIII**

EFFECTIVE DATE: November 10, 1999

I. Cost Finding and Cost Reporting

- A. Each hospital participating in the Florida Medicaid Hospital Program shall submit a cost report postmarked no later than 5 calendar months after the close of its cost reporting year. A hospital filing a certified cost report that has been audited by the independent auditors of the hospital shall be given a 30-day extension if the Agency for Health Care Administration (AHCA) is notified in writing that a certified report is being filed. The hospital cost reporting year adopted for the purpose of this plan shall be the same as that for Title XVIII or Title V cost reporting, if applicable. A complete legible copy of the cost report shall be submitted to the Medicare intermediary and to AHCA.
- B. Cost reports available to AHCA as of March 31, 1990, shall be used to initiate this plan.
- C. All hospitals are required to detail their costs for their entire reporting year making appropriate adjustments as required by this plan for determination of allowable costs. New hospitals shall adhere to requirements of Section 2414.1, Provider Reimbursement Manual, HCFA PUB. 15-1, as incorporated by reference in Rule 59G-6.010, Florida Administrative Code (F.A.C.) A prospective reimbursement rate, however, shall not be established for a new hospital based on a cost report for a period less than 12 months. For a new provider with no cost history, excluding new providers resulting from a change in ownership where the previous provider participated in the program, the interim per diem rate shall be the lesser of:
- a. the class reimbursement ceiling, if applicable; or

Amendment 99-15
Effective 11/10/99
Supersedes 98-17
Approval 1/20/00

- b. the budgeted rate approved by AHCA based on Section III of this plan.

Interim rates shall be cost settled for the interim rate period. Interim per diem rates shall not be approved for new providers resulting from a change in ownership. Medicaid reimbursement is hospital specific and is not provider specific.

- D. The cost report shall be prepared in accordance with the method of reimbursement and cost finding of Title XVIII (Medicare) Principles of Reimbursement described in 42 CFR 413.5 - 413.35 (1995) and further interpreted by the Provider Reimbursement Manual HCFA PUB. 15-1, as incorporated by reference in Rule 59G-6.010, F.A.C., except as modified by this plan.
- E. A hospital which does not file a cost report within 5 months after the close of its reporting period shall have its per diem rate reduced by 50 percent until such time that a report is filed. The loss imposed by this penalty shall be reimbursed retroactively upon receipt of the complete, legible cost report. Medicare granted exceptions to these time limits shall be accepted by AHCA.
- F. A hospital which does not file a cost report within 6 calendar months after the close of its reporting period shall have its provider agreement canceled.
- G. A hospital which voluntarily or involuntarily ceases to participate in the Florida Medicaid Program or experiences a change of ownership shall file a clearly marked "final" cost report in accordance with Section 2414.2, HCFA PUB. 15-1, as incorporated by reference in Rule 59G-6.010, F.A.C. For the purposes of this plan, filing a final cost report is not required when:
 - 1. the capital stock of a corporation is sold; or
 - 2. partnership interest is sold as long as one of the original general partners continues in the partnership or one of the original limited partners becomes a general partner, or control remains unchanged.

Any change of ownership shall be reported to AHCA within 45 days after such change of ownership.

- H. All Medicaid participating hospitals, are required to maintain the Florida Medicaid Log and financial and statistical records in accordance with 42 CFR 413.24 (a)-(c) (1995). In addition, a separate log shall be maintained to account for concurrent and non-concurrent nursery days. For purposes of this plan, statistical records shall include beneficiaries' medical records. These records shall be available upon demand to representatives, employees or contractors of AHCA, the Auditor General of the State of Florida, the General Accounting Office (GAO) or the United States Department of Health and Human Services (HHS). Beneficiaries' medical records shall be released to the above named persons for audit purposes upon proof of a beneficiary's consent to the release of medical records such as the Medicaid Consent Form, HRS-Med Form 1005, as incorporated by reference in Rule 59G-5.080, (2), F.A.C.
- I. Records of related organizations as defined by 42 CFR 413.17 (1995) shall be available upon demand to representatives, employees or contractors of AHCA, the Auditor General, GAO, or HHS.
- J. AHCA shall retain all uniform cost reports submitted for a period of at least 5 years following the date of submission of such reports and shall maintain those reports pursuant to the record keeping requirements of 45 CFR 205.60 (1995). Access to submitted cost reports shall be in conformity with Chapter 119, Florida Statutes. Upon request for a copy of any cost report, the hospital involved shall be notified as to the person making the request and what is being requested. Unless prohibited by a court of competent jurisdiction, the cost report shall be released to the requestor within a limited reasonable time from receipt of the request by the Agency for Health Care Administration. Reasonable time is

defined as the time allowed to enable the agency to retrieve the record and delete exempt portions of the record.

II. Audits

A. Background

Medicaid (Title XIX), Maternal and Child Health and Crippled Children's Services (Title V), and Medicare (Title XVIII) requires that inpatient hospital services be reimbursed on a reasonable cost basis. To assure that payment of reasonable cost is being achieved, a comprehensive hospital audit program has been established to reduce the cost of auditing submitted cost reports under the above three programs, and to avoid duplicate auditing effort. The purpose is to have one audit of a participating hospital that shall serve the needs of all participating programs reimbursing the hospital for services rendered.

B. Common Audit Program

AHCA has entered into written agreements with Medicare intermediaries for participation in a common audit program of Titles V, XVIII and XIX. Under this agreement the intermediaries shall provide AHCA the result of desk and field audits of those participating hospitals located in Florida, Georgia, and Alabama.

C. Other Hospital Audits

For those hospitals not covered by the common audit agreement with Medicare intermediaries, AHCA shall be responsible for performance of desk and field audits.

AHCA shall:

1. Determine the scope and format for on-site audits;
2. Desk audit all cost reports within 6 months after their submission to AHCA;

3. Ensure all audits are performed in accordance with generally accepted auditing standards of the AICPA, as incorporated by reference in Rule 61H1-20.008, F.A.C. (10/94);
4. Ensure that only those expense items that the plan has specified as allowable costs under Section III of this plan have been included by the hospital in the computation of the costs of the various services provided under Rule 59G-4.150, F.A.C.
5. Review to determine that the Florida Medicaid Log is properly maintained and current in those hospitals where its maintenance is required;
6. Issue, upon the conclusion of each full scope audit, a report which shall meet generally accepted auditing standards of the AICPA, as incorporated by reference in Rule 61H1-20.008, F.A.C., (10/94), and shall declare the auditor's opinion as to whether, in all material respects, the cost submitted by a hospital meets the requirements of this plan.

D. Retention

All audit reports received from Medicare intermediaries or issued by AHCA shall be kept in accordance with 45 CFR 205.60 (1995).

E. Overpayments and Underpayments

1. Overpayments for those years or partial years as determined by desk or field audit using prior approved State plans shall be reimbursable to AHCA as shall overpayments, attributable to unallowable costs only.
2. Overpayments in outpatient hospital services shall not be used to offset underpayments in inpatient hospital services and, conversely, overpayments in inpatient hospital services shall not be used to offset underpayments in outpatient hospital services.
3. The results of audits of outpatient hospital services shall be reported separately from audits of inpatient hospital services.

4. Any overpayment or underpayment that resulted from a rate adjustment due to an error in either reporting or calculation of the rate shall be refunded to AHCA or to the provider as appropriate.
5. Any overpayment or underpayment that resulted from a rate based on a budget shall be refunded to AHCA or to the provider as appropriate.
6. The terms of repayments shall be in accordance with Chapter 409.335, Florida Statutes.
7. All overpayments shall be reported by AHCA to HHS as required.
8. Information intentionally misrepresented by a hospital in the cost report shall result in the imposition of disciplinary action by the Florida Medicaid Program as provided for in Rule 59G-9.010, F.A.C.

F. Appeals

For audits conducted by AHCA, a concurrence letter that states the results of an audit shall be prepared and sent to the provider, showing all adjustments and changes and the authority for such. Providers shall have the right to a hearing in accordance with Section 59-1.018 (4), F.A.C, and Section 120.57, Florida Statutes, for any or all adjustments made by AHCA.

III. Allowable Costs

Allowable costs shall be determined using Title XVIII (Medicare) Principles of Reimbursement as described in 42 CFR 413.5 - 413.35 (1995) (excluding the inpatient routine nursing salary cost differential) and the guidelines in the Provider Reimbursement Manual HCFA PUB. 15-1, as incorporated by reference in Rule 59G-6.010, F.A.C., except as modified by Title XIX of the Social Security Act (the Act), this plan, requirements of licensure and certification, and the duration and scope of benefits provided under the Florida Medicaid Program. These include:

- A. Costs incurred by a hospital in meeting:

1. The definition of a hospital contained in 42 CFR 440.10 (1995) (for the care and treatment of patients with disorders other than mental diseases) and 42 CFR 440.140 (for individuals age 65 or older in institutions for mental diseases), (1995) in order to meet the requirements of Sections 1902(a)(13) and (20) of the Social Security Act;
 2. The requirements established by the Agency for establishing and maintaining health standards under the authority of 42 CFR 431.610 (b) (1995); and
 3. Any other requirements for licensing under Chapter 395.003, Florida Statutes, which are necessary for providing inpatient hospital services.
- B. Medicaid reimbursement shall be limited to an amount, if any, by which the per diem calculation for an allowable claim exceeds the amount of third party benefits during the Medicaid benefit period.
- C. Hospital inpatient general routine operating costs shall be the lesser of allowable costs, direct and indirect, incurred or the limits established by HHS under 42 CFR 413.30 (1995).
- D. Malpractice insurance costs shall be apportioned to Medicaid in the ratio of Medicaid Patient Days to Total Patient Days.
- E. Under this plan, hospitals shall be required to accept Medicaid reimbursement as payment in full for services provided during the benefit period and billed to the Medicaid program; therefore, there shall be no payments due from patients. As a result, for Medicaid cost reporting purposes, there shall be no Medicaid bad debts generated by patients. Bad debts shall not be considered as an allowable expense.
- F. All physician orders and records that result in costs being passed on by the hospital to the Florida Medicaid Program through the cost report shall be subject to review by AHCA on a random basis to determine if the costs are allowable in accordance with Section III of this plan. All such orders determined by the

Utilization and Quality Control Peer Review Organization (PRO) or the hospital's utilization review (UR) committee to be unnecessary or not related to the spell of illness shall require appropriate adjustments to the Florida Medicaid Log.

- G. Surgical procedures identified by AHCA in Appendix G of the Hospital Coverage and Limitations Handbook, under Rule 59G-4.150, F.A.C., shall require a second opinion, prior authorization or post authorization. Failure to meet the above requirements shall result in the disallowance of such charges associated with the surgical procedures. Appropriate adjustments shall be made to the Florida Medicaid Log.
- H. The allowable costs of nursery care for Medicaid eligible infants shall include direct and indirect costs incurred on all days these infants are in the hospital.
- I. The revenue assessments, and any fines associated with those assessments, mandated by the Health Care Access Act of 1984, Section 395.7015, Florida Statutes, shall not be considered an allowable Medicaid cost and shall not be allocated as a Medicaid allowable cost for purposes of cost reporting.
- J. For purposes of this plan, gains or losses resulting from a change of ownership will not be included in the determination of allowable cost for Medicaid reimbursement.

IV. Standards

- A. In accordance with Chapter 120, Florida Statutes, Administrative Procedures Act, and 42 CFR 447.205 (1995), this plan shall be promulgated as an Administrative Rule and as such shall be made available for public inspection. A public hearing shall be held so that interested members of the public shall be afforded the opportunity to review and comment on this plan.
- B. For purposes of establishing reimbursement ceilings, each hospital within the state shall be classified as teaching as defined in Section 407.002 (27), Florida Statutes, general, specialized or rural. An inpatient variable cost county reimbursement

ceiling shall be established for general hospitals. An inpatient variable cost class reimbursement ceiling shall not be established for specialized, statutory teaching or rural hospitals. An inpatient fixed cost reimbursement ceiling shall be established for all hospitals except rural hospitals and specialized psychiatric hospitals. Out-of-state hospitals shall be considered to be general hospitals under this plan.

- C. Reimbursement ceilings shall be established prospectively for each Florida County. Beginning with the July 1, 1991, rate period, additional ceilings based on the target rate system shall be imposed. The target rate ceiling shall be the approved rate of increase in the prospective payment system for the Medicare Inpatient Hospital Reimbursement Program as determined by the Department of HHS. For fiscal year 1991-1992, the allowable rate of increase shall be 3.3 percent. Effective July 1, 1995, the target rate ceiling shall be calculated from an annually adjusted Data Resource Inc. (DRI) inflation factor. The DRI inflation factor for this time period is 3.47 percent. With the adjustment of this DRI factor, the allowable rate of increase shall be 2.2 percent. Effective July 1, 1996, and for subsequent state fiscal years, the allowable rate of increase shall be calculated by an amount derived from the DRI inflation index described in appendix A. The allowable rate of increase shall be calculated by dividing the inflation index value for the midpoint of the next state fiscal year by the inflation index value for the midpoint of the current state fiscal year and then multiply this amount by 63.4 percent. The allowable rate of increase shall be recalculated for each July rate setting period and shall be the same during the remainder of the state fiscal year. These target ceilings shall apply to inpatient variable cost per diems (facility specific target ceilings) and county ceilings (county target ceilings) and shall be used to limit per diem increases during state fiscal years. Rural and specialized psychiatric hospitals are exempt from both of these target ceilings. All